

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM  
**CIMZIA (certolizumab)for Crohn's Disease**

Patient name:\_\_\_\_\_Medicaid ID #:\_\_\_\_\_

Prescriber Name:\_\_\_\_\_Prescriber NPI#:\_\_\_\_\_Contact person:\_\_\_\_\_

Prescriber Phone#:\_\_\_\_\_Extension/Option:\_\_\_\_\_Fax#:\_\_\_\_\_

Pharmacy:\_\_\_\_\_Pharmacy Phone#:\_\_\_\_\_Pharmacy Fax #:\_\_\_\_\_

Requested Medication:\_\_\_\_\_Strength:\_\_\_\_\_Frequency/Day:\_\_\_\_\_

**All information to be legible, complete and correct or form will be returned**

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**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF  
MEDICAL NECESSITY TO 855-828-4992**

**CRITERIA:**

- Age requirement: 18 years and older
- Diagnosis of moderate to severely active Crohn's Disease.
- Documented inadequate response to
  - conventional therapy (i.e. 5-aminosalicylates, antibiotics, MTX, 6-mercaptopurine, azathioprine, corticosteroids, or budesonide).

**OR**

- infliximab (remicade) (or intolerance to infliximab; please describe in detail)
- Negative TB skin test or history of treatment for latent TB infection.
- Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition.
- Cimzia may not be given with other biologic agents such as Interferon, experimental medications or combination.

**NOTES:**

Available as a Non-Traditional Medicaid Benefit.

**AUTHORIZATION:**

1 year

**RE-AUTHORIZATION:**

An updated letter of medical necessity or progress notes showing improvement with medication.

9/13/10

<http://health.utah.gov/medicaid/pharmacy>